Family Nurse Practitioner Residency for Recruiting and Retention

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ABSTRACT

Family nurse practitioner (FNP) residencies and fellowships are a new strategy for hiring and retaining skilled primary care providers and are supported by the Institute of Medicine. FNPs have been shown to benefit from increased support during their first year of practice. Margaret Flinter outlined a model of a 1-year FNP residency in a federally qualified health center with intensive orientations, assigned preceptors, and a gradual assumption of responsibilities. This model has been used to improve patient access, provider diversity, and provider retention. Three FNP residents can generate enough revenue to offset the nonproductive preceptor time.

Keywords: FQHC, postgraduate FNP education, preceptors, residency, transition to practice

Nurse practitioner residencies and fellowships are an emerging trend in postgraduate education. The Affordable Care Act has allowed millions of previously uninsured citizens to obtain health insurance. Along with the aging population of patients and providers, the shortage of primary care providers has been exacerbated.[1] Federally qualified health centers (FQHCs) and the family nurse practitioners (FNPs) working in them are uniquely placed to expand access to care. In December 2015, the Institute of Medicine released an update on the 2010 Future of Nursing Report, which continues to support transition-to-practice programs. The Association of Post Graduate APRN Programs has also called for accreditation of these programs to assure vigor and quality and to promote standardization (2015). The Association endorses the American Nurses Credentialing Center's practice transition accreditation program, which seeks to support evidenced-based best practices. The National Nurse Practitioner Training Consortium (associated with Margaret Flinter) is also developing an accreditation program (www.NNPRFTC.com/).

Flinter's seminal work[2] showed that new FNPs in primary care settings immediately start managing complicated patients with behavioral health and substance abuse issues, low health literacy, and a lack of access to specialists. Sargent and Olmedo[3] also found, with a novice FNP focus group, the desire for more support during practice due to a sense that the physician preceptors were unapproachable or too busy. There are many ways to provide support to new FNP graduates, including formal mentoring in private practices to structured residency or fellowship programs in clinics, large hospitals, and university settings.[4]

At this FQHC, full-scope FNPs practice to the full extent of their license. They treat a wide spectrum of patients and conditions with varying ages and complexity of symptoms. They perform all the duties required in an FQHC, from well-child checks to managing warfarin. The patients are uninsured (and often uninsurable) or underinsured. Thus, many patients are seen in-house that other clinics would refer out. Half are Spanish-speaking immigrants or their children. Finding skilled, culturally competent clinicians with intermediate verbal Spanish fluency has proven to be difficult. Before the residency program, FNPs would stay an average of 1 year after hire and then leave for less challenging settings.

In 2010, the medical director proposed an FNP residency. The clinic wrote a Health Resources and Services Administration (HRSA) grant in collaboration with the nursing faculty of Sonoma State University. The grant was approved in 2011 for implementation of a workforce development project.

The first residents were accepted in early 2012. Now, 3 or 4 residents are taken every 6 months for a 1-year program. Unlike the family medicine physician residents also hosted at the clinic, the FNP residents have no hospital rotations.

FNPs within their first 2 years of practice with strong internal medicine skills and verbal competence in Spanish are actively recruited. Candidates able and interested in being hired after the residency in a permanent capacity are also attractive. Nearby University of California, San Francisco provides excellent clinical experiences for their FNP students and this seems to correlate with competence in the FQHC setting. Local Sonoma State University has FNP graduates who are more likely to want to stay locally in a permanent position. Regardless of the educational background of the candidates, knowledge of FQHCs and a personal interest to serve the underserved are important. On the day of the interview, the candidates come to the weekly didactic lecture and stay to talk with the current FNP residents. The interview includes a question in Spanish about pediatric asthma and an internal medicine question about a diabetic patient with impaired renal function.

The program follows Flinter's description of a 1-year FNP residency in an FQHC setting.[2] It provides a supportive environment for novice FNPs to develop in their new role through a thorough orientation, assigned preceptors, and low but escalating productivity targets. FNP residents receive a 2-week orientation that introduces them quickly to the culture of the FQHC. Residents fall behind if they have poor electronic medical record skills, so the training is scheduled as early as possible and they shadow other providers and nurses. Residents receive training in motivational interviewing, the 4 Habits Model of efficient and effective patient visits, and contraceptive implant insertion and removal. Formularies are reviewed and resources are provided on safe prescribing practices. Examples include estrogen use in medically complicated patients, quick-start birth control, chronic pain management, and warfarin use. Orientation also includes a lunch meeting with the medical assistants who explain the best practices of teamwork.

The second fundamental aspect of the FNP residency is an assigned preceptor. For every 3 FNP residents who are seeing patients, there is an assigned preceptor who does not see patients during that clinic. The FNP residents have a license and usually see patients without the preceptor entering the exam room except in the case of difficult chronic pain patients. Another exception is when an ambulance is being called or if a patient refuses to go to the emergency room. Preceptors also double-check the novice FNP residents' prescriptions and reexamine patients in cases of otitis media, pharyngitis, wheezing, infections, and wounds. FNP residents seem to initially struggle with their assessment of acuity. See Table 1 for advice to preceptors.

The preceptor is expected to review resident progress notes during the clinic and is not given extra administrative time for this responsibility. Preceptors report a very high job satisfaction due to the lower stress and immediate rewards of teaching. Core preceptors include 2 FNPs (1 is the project director), a pediatrician, an internist, and a family physician who also does obstetrics and complicated office procedures. The preceptors have received training from the Department of Nursing at Sonoma State University using models evaluated by William Cayley.[5]

The final fundamental aspect of the model is the gradual escalation of responsibilities. The FNP residents inherit a panel of approximately 500 patients

Table 1. Advice for Preceptors

- *Before clinic:* Review every patient with the freshmen (residents in their first 6 months) and ask the seniors (in their second 6 months) if they have questions.
- *During clinics:* When residents present a well-child check, confirm immunizations, anemia screening, growth and development, and dental referrals. For diabetics, ask about kidney function and blood pressure. Use precepting time to review progress notes from previous clinics.
- *After clinic:* Stay until everyone has finished with their patients. When reviewing freshmen progress notes, preceptors should monitor prescriptions and labs. For all FNP residents, monitor kidney function in diabetics and hypertensives, safe insulin use (eg, mealtime, not bedtime, rapid-acting), as well as estrogen, warfarin, and other high-risk medications with a narrow range of efficacy or other safety issues.

Table 2. Family Nurse Practitioner Resident Typical Weekly Schedule

- 3 continuity clinics (seeing their patients and those of their preceptors).
- 1 internal medicine clinic (teaching model with a team approach).
- 1 pediatric clinic.
- 1 patient group visit (pediatric obesity, diabetes, newborn, etc.).
- 1 specialty clinic (gastroenterology, dermatology, etc.).
- 1 didactic of 1.5 hours.
- 4^{+} hours administrative time plus staff meetings.

(regular full-time providers have approximately 1,000). For the first 3 months, a preceptor signs off on all the residents' labs, imaging, and patient plans. For the first 6 months, the residents send all of the progress notes to the preceptor of that clinic for review. Thereafter, only notes for high-risk patients are sent to the preceptor (chronic pain, uncontrolled diabetes, polypharmacy, etc.). FNP resident productivity starts low with 1 patient per hour and, by the end of the year, 9 patients in 4 hours. Residents work a 40-hour week, which includes 1 evening per week and 1 or 2 Saturdays per month. Some handle the call phone for after-hours advice. They present 2 or 3 case studies in didactic during the 12-month program and their final project is a presentation of a medical guideline update at the morning provider meeting. See Table 2 for a typical schedule.

Balancing the budget has been one of the biggest challenges since the HRSA grant expired. The productivity of the FNP residents barely offsets the cost of the nonproductive preceptors. FNPs are licensed and the patient visits are billable, but it would be more lucrative for the clinic to hire 1 experienced, full-scope provider instead of 3 residents. However, the softer outcomes of patient access, provider diversity, and provider retention make the program attractive to leadership. Also, the FNP residents are well-versed in the chronic care model and attentive to routine health maintenance. This helped garner Medicaid bonuses for meeting meaningful use and quality improvement project standards. The budget goal is to bill 1,900 patient encounters a year per resident, although 1,700 is adequate for the sustainability of the program. FNP residents are paid 80% of a starting FNP salary, receive full benefits, and are part of the union.

The program has produced 12 graduates so far. Ten are working as FNPs in primary care settings and 6 in FQHCs; 2 have gone back to nursing. Four of the graduates were hired internally. Of 18 total residents past and present, 10 are ethnic minorities. Patient satisfaction is an area that needs more study. The extra time and attention the FNP residents can give a patient may be outweighed by the possibility of a longer waiting-room time.

In conclusion, practicing in an FQHC as a new FNP can be challenging. The patients are often complicated, with complex medical issues, and are either uninsured or underinsured. FNPs in their first year of practice benefit from the supportive environment of residencies and fellowships through intensive orientation, dedicated preceptors, and gradually increasing responsibilities. The outcomes of our program show success in training clinicians who stay in primary care. JNP

References

1. Institute of Medicine. *Assessing Progress on the Institute of Medicine Report the Future of Nursing*. Washington, DC: National Academies Press; 2015.
2. Flinter M. *From New Nurse Practitioner to Primary Care Provider: A Multiple Case Study of New Nurse Practitioners Who Completed a Formal Post-graduate Residency Training*. ProQuest Dissertations Publishing; 2010. http://www.proquest.com/.
3. Sargent L, Olmedo M. Meeting the needs of new-graduate nurse practitioners: a model to support transition. *J Nurs Admin*. 2013;43(11):603-610.
4. Hill L, Sawatzky J. Transitioning into the nurse practitioner role through mentorship. *J Prof Nurs*. 2011;27(3):161-167.
5. Cayley W. Effective clinical education: strategies for teaching medical students and residents in the office. *Wisc Med J*. 2011;110(4):181.

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